POC #2 Accepted T.T.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey and complaint investigation #33227 conducted at Donelson Place Care and Rehabilitation, on February 5, 2014, no deficiencies were cited in relation to the complaint.	F 000	**Disclaimer:** Donelson Place does not believe and does not admit that any deficiencies existed before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of resident council minutes, the facility failed to ensure an acceptable noise level for three (#54, #66, #157) of thirty-four residents reviewed. The findings included: Observation of the facility during initial tour on February 3, 2014, at 10:00 a.m., during shift change on February 4, 2014, at 2:45 p.m., and on February 5, 2014, at 7:10 a.m., revealed the halls to be very noisy with staff calling out to one another; therapy calling to staff regarding resident whereabouts; nurses calling to one another about admissions; and residents wheeling themselves down the hall and calling out repetitiously. During the resident interview conducted on February 4, 2014, at 7:59 a.m., in the resident's room, regarding noise level in the facility, resident #54 stated, "...people are constantly in the hall chattering; buzzers keep going off; nurses are	F 258		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: for Kathleen Webb, RN BNS

TITLE: BNS

(X6) DATE: 2/21/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 258	Continued From page 1 hollering; and the buzzers are loud even with the door closed..." During the resident interview conducted on February 4, 2014, at 8:26 a.m., in the resident's room, regarding noise level in the facility, resident #66 stated, "...the nurses are noisy..." During the resident interview conducted on February 4, 2014, at 8:43 a.m., in the resident's room, regarding noise level in the facility, resident #157 stated, "...at shift change it is very noisy and scared me twice..." Review of resident council minutes dated December 16, 2013, revealed a resident concern, "...staff was loud at night, 9:00 p.m. and later, calling to each other down the hallway..." Review of resident council minutes dated January 9, 2014, revealed a resident concern, "...day time staff were yelling..." Review of resident council minutes dated February 4, 2014, revealed a resident concern, "...day time staff were loud; staff socialized in the hallway and during care taking time..." Medical record review revealed resident #54 was moved to a different room on February 4, 2014. Continued medical record review of a Social Services Progress Note dated February 4, 2014, with no time, revealed the resident liked the new room and stated, "...it's so quiet here..." Interview with the Administrator on February 5, 2014, at 1:25 p.m., in the administrative conference room, confirmed staff had to be in-serviced on noise levels due to complaints of	F 258	**F 258 Maintenance of Comfortable Sound Levels** The facility must provide for the maintenance of comfortable sound levels. **Residents affected:** Residents identified were interviewed by social services to address any immediate needs associated with the noise level. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. Staff will be educated on noise level in the facility by their department head and/or designee. **Systemic measures:** The department heads and/or designees will in-service their staff on noise levels. Department heads during rounding throughout the week will listen for loud noises from staff and/or equipment and immediately address if identified. Weekend Managers will also conduct three rounds during their assigned shift. These rounds by department heads and Weekend Managers will take place on both shifts x 2 months. The department heads will carry walk talkies to cut down on overhead paging. The quality of life director/designee will address noise levels in the resident council meeting monthly x 2 months and report findings to the administrator. **Monitoring measures:** The administrator will discuss noise levels identified with the departments and monthly in QA x 2 months and upon occurrence thereafter.	3/22/14

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F 258	Continued From page 2 noise from residents.	F 258		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 356	**F356 Posted Nurse staffing information** The facility must post the following information on a daily basis – facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift to include registered nurses, licensed practical nurses or vocational nurses, certified nurse aides and resident census. **Resident affected and potentially affected:** All residents have the potential to be affected by this cited practice related to staffing. The posted daily staffing sheet was corrected on 2/3/2013 by the SDC to reflect the correct nursing staff on duty. **Systemic Measures:** The SDC/designee will post the daily nursing staffing sheet each day to reflect the current nursing staff on duty and the Weekend manager will post the staffing numbers on the weekend. The DON/designee throughout the work week will review nursing staffing data for accuracy. Staffing concerns identified on the posted staffing sheet will be addressed with the SDC/designee and corrected immediately. Licensed staff will be educated on revising the nursing staffing sheet that is posted to reflect actual nursing staff and hours worked. The DON/designee will report discrepancies identified on the posted nursing sheet to the administrator weekly x 4 weeks. **Monitoring changes:** The DON/designee will report discrepancies related to the posted staffing sheet to the administrator weekly x 4 weeks. Any concerns with posted nursing sheet will be addressed immediately and discussed in monthly QA x 2 months and upon occurrence thereafter.	3/22/14

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F 356	Continued From page 3 failed to post the current facility staff hours. The findings included: Observation on February 3, 2014, at 10:20 a.m., in the hall in the administrative office area, revealed the Daily Staffing form was dated January 30, 2014. Interview on February 3, 2014, at 10:25 a.m., in the hall in the administrative office area, with the Staffing Coordinator, confirmed the staffing report posted was not current.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain a sanitary walk-in refrigerator; failed to dispose of outdated leftovers; and failed to maintain dietary equipment in a sanitary manner in the dietary department. The findings included:	F 371	**F 371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** The facility must Store, prepare, distribute and serve food under sanitary conditions. **Residents affected and potentially affected:** All residents have the potential to be affected by this cited practice. Outdated food was disposed of in the trash. Blackened debris noted on the vents, ceiling and fans were cleaned. The black debris on the grill top and burnt debris in the spill pan was cleaned. The Dietary manager/designee will educate dietary staff on food storage and debris in the kitchen. **Systemic measures:** The dietary manager/designee will educate dietary staff on food storage and debris in the kitchen. The dietary manager/designee will audit the walk in refrigerator twice a week for four weeks. The dietary manager/designee will inspect the ceiling, vents and fans in the kitchen for debris weekly x 4wks. Any concerns identified with debris will be addressed immediately and reported to the maintenance department. The dietary manager/designee will notify the administrator when concerns related to sanitation of the kitchen are observed. **Monitoring measures:** The administrator will discuss and review sanitation concerns identified in the kitchen and corrections in monthly QA upon occurrence.	3/22/14

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F 371	Continued From page 4 Observation and interview with the Dietary Director in the dietary department, on February 3, 2014, at 9:52 a.m., confirmed there was blackened debris hanging from the ceiling in the walk-in refrigerator. Further observation and interview confirmed the dietary department reach-in refrigerator contained chicken noodle soup, soup, and tropical juice dated January 29, 2014. Observation and interview with the Dietary Director in the dietary department, on February 4, 2014, at 9:00 a.m., confirmed the ceiling vents and areas around the ceiling vents had an accumulation of blackened debris over the equipment storage area, food production area, and the tray line area. Further observation and interview confirmed the wall mounted fan in the dish room had a heavy accumulation of blackened debris on the fan grate and blades. Further observation and interview confirmed the grill top was black with discoloration and the range top spill pan had a heavy accumulation of burnt, blackened food debris present. Review of the facility policy entitled Food Storage, revealed "...Leftover food is used within 72 hours or discarded..."	F 371	**F 456 Essential Equipment, Safe Operating Condition** The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. **Residents affected or potentially affected:** All residents have the potential to be affected by this cited practice. The microwave was immediately removed by the maintenance director and a replacement was ordered. The floors in the walk in freezer/refrigerator will be repaired. The microwave was delivered to the facility and installed by 2/7/14. **Systemic measures:** The dietary manager/designee will report equipment or any unsafe operating conditions in the kitchen that is in poor condition or in need of repair or replacement to the maintenance department. The maintenance department will get an estimate for the repairs to the flooring in the walk-in refrigerator and freezer by 2/28/14. The maintenance department will conduct a walkthrough of the kitchen twice a month for 2 months observing for unsafe conditions or equipment in need of repair. The Administrator will conduct monthly kitchen safety audits x 2 months. Any safety concerns will be addressed immediately with the dietary manager/designee. **Monitoring measures:** The Maintenance director will report to the administrator unsafe conditions or equipment that needs repaired or replaced in the kitchen. The administrator will discuss and review in monthly QA x 2 months and upon occurrence thereafter.	3/22/14
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 456		

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F 456	Continued From page 5 Based on observation and interview, the facility failed to maintain a microwave and the floors in the walk-in freezer and walk-in refrigerator in safe operational condition in the dietary department. The findings included: Observation and interview with the Dietary Director on February 3, 2014, at 9:52 a.m., in the dietary department, confirmed the floors in the walk-in freezer and walk-in refrigerator were worn with areas of rust. Observation and interview with the Dietary Director on February 4, 2014, at 9:00 a.m., in the dietary department, confirmed the microwave interior door plastic cover was cracked in two areas. Further observation and interview confirmed the plastic interior door cover of the microwave had a blackened scorch mark in an area that appeared melted. Further interview confirmed the facility failed to maintain the dietary equipment in safe operating condition.	F 456	**F 514 RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. **Residents affected:** Resident #130 diet was confirmed by the dietary manager, DON, RD and administrator with the state surveyor on 2/5/13 to ensure correct diet was being delivered. Order was obtained for diet and pharmacy was notified of recapitulation error on physician order sheet. **Residents potentially affected:** All residents could have potentially been affected by this cited practice. All resident diets were checked in their charts for accuracy and compared to the diet in the dietary tray delivery system. Diets orders were confirmed with MD order. **Systemic measures:** Licensed nursing staff will be in-serviced on transcribing physician orders; ensuring current orders are transcribed onto new physician order sheet during end of month change over. The DON/designee will complete an audit of 25 % of all resident charts monthly x 2 months. Pharmacy recapitulation discrepancies will be reported to the pharmacy director for process improvement. **Monitoring Change:** Physician orders and 24 hour report will be reviewed throughout the work week during clinical meeting to ensure diet orders are transcribed correctly. Meeting takes place 5 days a week. On Mondays, a review of the last three (3) days will be completed. DON/designee will complete an audit of 25% of Physician Order Sheets after change over and report any concerns to monthly QA and pharmacy director x 2 months and upon occurrence thereafter.	3/22/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		

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F 514	Continued From page 6 and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#130) of thirty-four resident records reviewed. The findings included: Resident #130 was admitted to the facility on September 4, 2013, with diagnoses including Left Hip Fracture, Parkinson's, Open Reduction Internal Fixation Left Hip, Urinary Retention, Arthritis, Transient Ischemic Attack, Cerebrovascular Accident, Left Shoulder Fracture, and Anemia. Medical record review of a hospital transfer report dated September 4, 2013, revealed, "...Diet: Mechanical Soft..." Medical record review revealed the facility diet orders were as follows: Admission, September 4, 2013: Regular Diet Mechanical Soft; October and November 2013 Recapitulation Orders: Diet-Regular; Telephone order dated November 8, 2013: Change diet to Mechanical Soft; December 2013 and January 2014 Recapitulation Orders: Diet-Regular; Telephone order dated January 11, 2014: "...1. DC (Discontinue) Regular diet, 2. Mech (Mechanical) Soft diet..."; and February 2014 Recapitulation Orders: Diet-Regular.	F 514		

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F 514	Continued From page 7 Interview on February 5, 2014, at 3:25 p.m., with the Administrator, Director of Nursing, Registered Dietitian, and Dietary Director, in the conference room, confirmed the facility pharmacy failed to transcribe the diet order per the physician orders and the facility staff failed to review and correct the recapitulation orders to reflect the physician diet orders. Further interview confirmed the facility failed to maintain an accurate medical record.	F 514		